Petition for Rulemaking

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Petition for Rulemaking

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1. Request

Under G.S. 150B-20 and 11 NCAC 01 .0209, I petition the Department to adopt a new rule implementing G.S. 58-56A-3(c1). No existing rule is proposed for amendment or repeal. I ask the Department to assign the new rule the chapter and section number it considers appropriate.

Statutory authority for the rule: G.S. 58-2-40(1), G.S. 58-56A-3, and G.S. 150B-20.

2. The statute

G.S. 58-56A-3(c1) provides:

"When calculating an insured's contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or other applicable cost-sharing requirement, the insurer or pharmacy benefits manager shall include any amounts paid by the insured, or on the insured's behalf, for a prescription that is either: (1) Without an AB-rated generic equivalent. (2) With an AB-rated generic equivalent if the insured has obtained

authorization for the drug through any of the following: a. Prior authorization from the insurer or pharmacy benefits manager. b. A step therapy protocol. c. The exception or appeal process of the insurer or pharmacy benefits manager."

The subsection then provides a limited exception for an insured covered by a high deductible health plan, as defined in section 223 of the Internal Revenue Code, where applying the subsection would render the insured ineligible for a health savings account, unless the minimum deductible under section 223 has been satisfied or the prescription qualifies as preventive care under section 223.

3. Draft of the proposed rule

COUNTING AMOUNTS PAID ON BEHALF OF AN INSURED TOWARD COST SHARING UNDER G.S. 58-56A-3(c1)

(a) Duty. When calculating an insured's contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or other applicable cost-sharing requirement, each insurer that issues, delivers, amends, or renews a health benefit plan in this State, and each pharmacy benefits manager that administers pharmacy benefits under such a plan, shall include the amounts described in Paragraph (b) of this Rule. The duty in G.S. 58-56A-3(c1) applies to the insurer and to the pharmacy benefits manager. It is not an election between them.

(b) Amounts to be included. Any amount paid by the insured, or on the insured's behalf, for a prescription drug, including an amount paid by a manufacturer copayment assistance program, where the drug either has no AB-rated generic equivalent, or has an AB-rated generic equivalent and the insured obtained authorization for the drug through prior authorization, a step therapy protocol, or the insurer's or pharmacy benefits manager's exception or appeal process.

(c) How amounts are to be included. An amount described in Paragraph (b) shall be credited dollar for dollar toward each cost-sharing requirement the plan imposes for that insured, including a deductible. Where a plan states that a prescription drug deductible is integrated with the medical deductible, the amount shall be credited toward that integrated deductible. An insurer shall not credit such an amount toward an out-of-pocket maximum while excluding it from a deductible the plan imposes.

(d) Delegation does not relieve the insurer. An insurer does not satisfy this Rule by contracting with a pharmacy benefits manager, specialty pharmacy, or other vendor. The insurer shall obtain and maintain records sufficient to show, for each fill, the amount paid by or on behalf of the insured and the amount credited toward the deductible and toward

the out-of-pocket maximum, and shall produce those records to the insured or to the Department upon request.

(e) High deductible health plan exception. The exception in G.S. 58-56A-3(c1) applies only where the plan is a high deductible health plan as defined in section 223 of the Internal Revenue Code and applying Subsection (c1) would render the insured ineligible for a health savings account, and only to the extent the statute provides. An insurer relying on the exception shall document the basis for relying on it, including why the plan qualifies under section 223. A plan that provides copayments for office visits or other services that are not subject to the deductible is not, on that basis alone, to be treated as a high deductible health plan for purposes of this Rule without that documentation.

(f) Nothing in this Rule limits any other requirement of G.S. 58-56A-3 or of Chapter 58.

4. Why the rule is requested

I am the father of the insured, [redacted] age 17, the sole member on Ambetter of North Carolina Inc. policy [redacted], Ambetter Standard Gold, effective January 1, 2026. The 2026 Schedule of Benefits (form 77264NC0010046-01-2026) states a $2,000 individual deductible and states, for the prescription drug deductible, "Integrated with medical deductible."

My son takes [redacted] for severe [redacted], [redacted] has no AB-rated generic equivalent. A manufacturer program pays his $250 Tier 4 specialty copay on each fill.

Ambetter credits that $250 to his out-of-pocket maximum and credits $0.00 of it to his deductible. That is not in dispute. Ambetter stated it in writing to this Department on June 22, 2026: set copayments "are applied toward the member's MOOP and do not accumulate toward the deductible." Its own 2025 Accumulator Report, prepared May 6, 2026, shows five [redacted] fills in 2025 (August 19, September 10, October 14, November 14, and December 12), $250 each, with $0.00 in the column headed "Applied to Deductible" on every one. As of October 4, 2026, the member portal showed $159.41 of the $2,000 deductible met and $3,104.41 of the $8,200 out-of-pocket maximum met.

The plan is not a high deductible health plan under section 223. It pays flat copays of $30 for a primary care visit, $60 for a specialist, $45 for urgent care, and $30 for a virtual visit, none of them subject to the deductible. Ambetter raised the high deductible health plan theory by phone on May 1, 2026 and abandoned it within days after I answered it in writing.

I filed a complaint with the Department, File 2026-04-01767. The Department declined to require Ambetter to credit the deductible. As I understand the Department's position, communicated by its consumer analyst on June 15, 2026 and again on October 6, 2026 after the file was reopened, it is that Subsection (c1) binds the pharmacy benefits manager and not the insurer, and that the legislative law I cite does not apply to this issue. No written statement of the reasoning has been provided, although I asked for it on October 6, 2026, and the Deputy Commissioner who was consulted has not been identified to me.

That reading leaves the statute with no one to bind:

1. The pharmacy benefits manager in this plan, Express Scripts, does not maintain the deductible. The Schedule of Benefits states that the prescription drug deductible is integrated with the medical deductible. There is one ledger, and the insurer holds it.
2. Ambetter has never taken the position the Department takes for it. When the Department asked Ambetter how the $250 was applied, Ambetter's compliance officer answered on company letterhead and described the treatment as Ambetter's own plan design.
3. If Subsection (c1) does not bind the insurer, and the pharmacy benefits manager cannot credit a deductible it does not maintain, then no party is bound and a subsection enacted without a dissenting vote in either chamber does nothing.

Two further matters in the complaint record are relevant to why a rule, and not another individual complaint review, is needed. On June 22, 2026 the Department asked Ambetter in writing to confirm that there is no deductible for prescription drugs in the policy contract, and to explain the "integrated with medical deductible" language. Ambetter answered neither question, and the file was closed. The Schedule of Benefits Ambetter filed with that response was the 2025 form, showing a $1,500 deductible, in a complaint about the 2026 plan year. On October 7, 2026, after I asked for the 2026 Accumulator Report, Ambetter posted Explanations of Benefits to the portal instead. That report has still not been produced.

The practical consequence is concrete. My son injured his right knee on January 17, 2026. An MRI was quoted at $1,984 through insurance. I paid $700 cash for it on June 8, 2026. The June 9, 2026 report describes a possible medial posterior horn meniscal tear, a low-grade ACL sprain, a 2.3 cm perimeniscal cyst, and joint effusion. He has had no orthopedic follow-up since, because of cost. Had the manufacturer amounts been credited as Subsection (c1) requires, his deductible would have been satisfied in July 2026.

5. Effect of the proposed rule on existing rules, orders, and Department procedures

The proposed rule does not amend or repeal any existing rule, and I am not aware of any existing rule, order, or bulletin that addresses how amounts paid on an insured's behalf are to be credited under G.S. 58-56A-3(c1). It would implement a statute that has been in effect since October 1, 2021. Its effects would be:

4. Insurers and pharmacy benefits managers operating in North Carolina would have one stated standard for accumulator treatment, instead of a standard that depends on which of them a complaint happens to reach.
5. The Department's consumer services staff would have a rule to apply in individual complaints, and its market regulation staff would have a rule to test against in market analysis and market conduct examinations, as that division already tests carriers against the General Statutes. The Department's Market Conduct Examination of Ambetter of North Carolina Inc., report dated February 28, 2025, cited violations of G.S. 58-50-61, 58-50-62, 58-3-225, and 58-3-200(d).
6. Insureds would be able to obtain, and insurers would be required to keep, a per-fill record of what was credited to the deductible and to the out-of-pocket maximum. At present an insured cannot verify his own accumulator without a report the insurer may decline to produce.

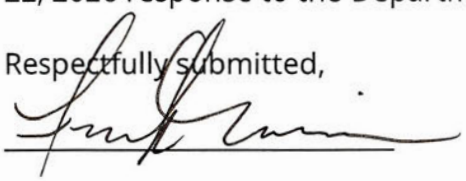
The amounts at issue are paid by manufacturers, not by insureds and not by insurers. Crediting them toward a deductible does not require an insurer to pay for a drug it has not already agreed to cover. It affects when an insured's deductible is satisfied and therefore when the plan's own cost sharing begins.

6. Relief requested

Grant this petition and initiate rulemaking proceedings. If the Department denies it, G.S. 150B-20 and 11 NCAC 01 .0209 require that I be sent a written statement of the reasons for the denial. I ask in particular that any denial address two questions: if Subsection (c1) does not bind the insurer, who does it bind, and how does a pharmacy benefits manager credit a deductible it does not maintain?

I am not represented by an attorney. I can supply the documents cited above, including the 2026 and 2025 Schedules of Benefits, the 2025 Accumulator Report, Ambetter's June 22, 2026 response to the Department, and the October 4, 2026 portal accumulator views.

Respectfully submitted,



10/21/2026